(i) Each provider shall submit documentation to show the calculation of the weighted average extra charges.

(ii) Failure to submit the documentation may delay the effective date of the weighted average private pay rate in the registry until the complete documentation is received.

(4) The weighted average private pay rate shall be based on what the provider receives from the resident. If the private pay charges are consistently higher than what the provider receives from the residents for services, then the average private pay rate for comparable services shall be based on what is actually received from the residents. The weighted average private pay rate shall be reduced by the amount of any discount received by the residents.

(5) The private pay rate for medicare skilled beds shall not be included in the computation of the average private pay rate for nursing facility services.

(6) When providers are notified of the effective date of the Kansas medical assistance program rate, the following procedures shall be followed:

(A) If the private pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry.

(B) Providers who are held to a lower private pay rate and subsequently notify the agency in writing of a different private pay rate shall have the Kansas medical assistance program rate adjusted on the later of the first day of the month following the date upon which complete private pay rate documentation is received or the effective date of a new private pay rate.

(c) Rate for new construction or a new facility to the program.

(1) The per diem rate for newly constructed nursing facilities or a new facility to the Kansas medical assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

(2) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider. The payment rate for the first 12 months of operation shall be based on the rate established from the historical cost data of the previous owner or provider. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(e) Per diem rate errors.

(1) When the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation, unless other arrangements have been made to reimburse the agency. A net settlement may occur when a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(f) Out-of-state providers. The rate for out-of-state providers certified to participate in the Kansas Kansas medical assistance program shall be the rate approved by the agency. Out-of-state providers shall obtain prior authorization by the agency.

(g) Determination of the rate for nursing facility providers reentering the medicaid program.

(1) The per diem rate for each provider reentering the medicaid program shall be determined from either of the following:

(A) A projected cost report in those cases in which the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the last historic cost report filed with the agency, if the provider has actively participated in the program during the most recent 24 months. The appropriate historic and estimated inflation factors shall be applied to the per diem rate determined in accordance with this paragraph.

(2) When the per diem rate for a provider reentering the program is determined in accordance with paragraph (1)(A) of this subsection, a settlement shall be made in accordance with K.A.R. 30-10-18(e).

(3) When the per diem rate for a provider reentering the program is determined in accordance with paragraph (1)(B) of this subsection, a settlement shall be made only on those historic cost reports with fiscal years beginning after the date on which the provider re-entered the program.

(h) Approved reserved days as specified in K.A.R. 30-10-21 shall be paid at 67 percent of the Kansas medical assistance program per diem rate.

(i) This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1999.)

30-10-19. Rates; effective dates. (a) Effective date of per diem rates for on-going providers filing calendar year cost reports. The effective date of a new rate that is based on information and data in the nursing facility cost report for the calendar year shall be the following July 1st.

(b) Effective date of the per diem rate for a new provider operating on the rate from cost data of the previous provider.

(1) The effective date of the per diem rate for a new provider shall be the date of certification by the department of health and environment.

(2) The effective date of the per diem rate based on the first historical cost report filed in accordance with K.A.R. 30-10-17 shall be the first day of the month following the end of the cost reporting period. Any rates paid after the effective date of the rate based on the first historical cost report shall be adjusted to the new rate from the historical cost report.

(c) Effective date of the per diem rate from a projected cost report.

(1) The effective date of the per diem rate based on a projected cost report for a new provider, as set forth in subsections (c), (d), and (g) of K.A.R. 30-10-18, shall be the date of certification by the department of health and environment.

(2) The interim rate determined from the projected cost report filed by the provider shall be established by the agency and given to the fiscal agent on or by the first day of the third month after the receipt of a complete and workable cost report.

(3) The effective date of the final rate, determined after an audit of the historical cost report filed for the projected cost report period, shall be the date of certification by the department of health and environment.

(4) The second effective date for a provider filing an historic cost report covering a projected cost report period shall be the first day of the month following the last day of the period covered by the report, which is the date that the inflation factor is applied in determining prospective rates.

(d) Each provider shall receive a new rate for each quarter when:

(1) there is a change in the average case mix index for the facility from previously submitted assessments; and

(2) the allowed per diem cost in the health cost center changes due to a change in the health care cost center limit as adjusted by the case mix.

(e) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997.)

30-10-20. Payment of claims. (a) Payment to participating providers. Each participating provider shall be paid, at least monthly, a per diem rate for nursing facility services, excluding resident liability, rendered to eligible resident provided that:

(1) the agency is billed on the turn-around document or electronic claims submission furnished by the contractor serving as the fiscal agent for the medicaid/medikan program;

(2) the turn-around document or electronic claims submission is verified by the administrator of the facility or a designated key staff member; and

(3) the claim is filed no more than twelve months after the time the services were rendered pursuant to K.S.A. 39-708a, and any amendment thereto.

(b) Residents liability. The resident's liability for services shall be the amount determined by the local agency office in which a medicaid/medikan resident or the resident's agent applies for care. The resident's liability begins on the first day of each month and shall be applied in full prior to any liability incurred by the medicaid/medikan program. The unexpended portion of the resident's liability payment shall be refunded to the resident or resident's agent if the resident dies or otherwise permanently leaves the facility.

(c) The payment of claims may be suspended if there has been an identified overpayment and the provider is financially insolvent.

(d) The effective date of this regulation shall be April 1, 1995. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended April 1, 1995.)